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Narratives in Oncology

You and Whose Army?

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I sing of a man who laid down his arms.

On Friday, August 24th, 2018, the family of U.S. Senator John McCain issued a statement that was remarkably clear-eyed in its assessment of his imminent mortality as an octogenarian with incurable brain cancer: "the progress of disease and the inexorable advance of age render their verdict." It continued to note that, "with his usual strength of will, he has now chosen to discontinue medical treatment."

He died the next day.

Tributes to the Senator have commingled his struggle with terminal illness and the heroism of his meritorious and torturous tour of duty in Vietnam. But his cancer and his service in the armed forces are two separate chapters of his life that should be kept distinct. He was a former prisoner of war who is—even posthumously—held captive by a different value system, where inaction can too readily be interpreted as weakness.

It does not help matters that his malignancy belonged to a particularly petrifying group of tumors that can cause even a seasoned oncologist to quake. Glioblastoma multiforme is a fearsome foe indeed. I can still remember the first time I saw it on a scan, a bullet with butterfly wings lodged irretrievably deep in the skull, alighting on the corpus callosum to span both hemispheres. If the cerebrum is the body's most valuable real estate, then glioblastoma multiforme is a land baron, a greedy occupier who cannot be evicted by the most skilled neurosurgeon's blade. Anyone facing this cancer must indeed summon valor to undergo life-prolonging treatment.

But there is a larger issue here with the semantics of sickness. We have, perversely, allowed our medical vocabulary around cancer to mutate into the parlance of combat.

No other disease evokes such talk of conflict. Even the more prevalent illnesses lack oncology's arsenal of hoary battlefield clichés; there are no wars against emphysema or hypertension. Heart attacks may be a byword for seriousness and cause chest-clutching bodies to fall, but there is no grand campaign against the clogging of coronaries. Cardiologists call the left anterior descending artery the widowmaker, yet more husbands are claimed by cancer than that sclerotic vessel.

Only this class of diagnoses brings with it the lexicon of aggressive self-defense. An obituary for a patient with cancer is just as—more?—likely to mention battle as is one for a veteran. Post mortem, the corpse is held high as a Trojan Horse from which bellicose cells have burst forth.

When you are diagnosed with cancer, you are conscripted in a draft you cannot dodge. Almost as insidious as the disease itself is the language surrounding it, through which even dyed-in-the-wool pacifists get recast as warriors. There is no conscientious objection here. Malignancy turns lambs to lions and then slaughters them anyway.

Some people receive double honors. I spent eight years of my training at a veterans' hospital, where I saw many minds of the greatest generation lost to tumors. The G.I. who stormed Normandy, dodging machine guns on the beachhead, would later receive plaudits when he tried to reverse the process and repel the invasion of his interior by would-be overlords. He might have survived the Nazis on D-Day but, in the end, he could still become cannon fodder for a doctor with abundant ammo and indiscriminate aim.

Tellingly, these references to conflict are most often deployed by civilians (myself included) who have never been in a firefight, have never been gashed by concertina wire or patched a bullet hole with soiled camo. Alopecia in the chemo ward is not equivalent to baldness in the barracks, where the shiny scalps reflect a much different sacrifice. When fending off a malignancy, you are not volunteering; you are dragooned into the cause of self-preservation, pulling the wrong number in the genetic lottery. The ordnance now is measured in milligrams, not megatons. Medicine becomes materiel, and someone else is pulling the trigger.

So: who, then, should we blame for the bombast, this metaphor-as-illness? The oncologist may be the guiltiest, encouraging patients to "fight on" with all the knowingness of a noncombatant. Warlike rhetoric during treatment also makes the tonal shift to hospice all the more startling. Having emptied our magazines, suddenly we command our troops to de-escalate, fully aware that cancer will not respect a détente. Talk of heroism at the beginning of therapy leads our charges to believe that their end will be a blaze of glory. We promise a Sherman's March toward exhausting every resource against their cancer. The future is binary: triumphant victory or burial in scorched earth. No wonder it seems so incongruous when we preach surrender, flip-flopping from Total War to a limp white flag.

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It is beyond question that there is tremendous courage to be found in every infusion suite where patients receive chemo. But there is also bravery in the decision to say no, in the person who assesses the dual threats to their body—the cancer and the oncologist—and decides not to engage.

As an ersatz general prone to friendly fire, I have cared for thousands of patients with cancer, and I have never met a coward.

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